STATE

MEDICARE PLUS $100,000

Group Health Insurance

WISCONSIN GROUP INSURANCE BOARD

DEPARTMENT OF EMPLOYEE TRUST FUNDS
P. O. Box 7931
801 West Badger Road
Madison, Wisconsin 53707-7931

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BlueCross & BlueShield
United of Wisconsin
An independent licensee of the Blue Cross
and Blue Shield Association

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GENERAL CONDITIONS

Blue Cross Blue Shield United of Wisconsin administers the CONTRACT as of January 1, 2001.

In the event of a conflict between the CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

COMPARISON OF OTHER STATE PLANS TO MEDICARE PLUS $100,000

The change from Blue Cross and Blue Shield United of Wisconsin (BCBSUW) Standard/Standard II/SMP to the Blue Cross Blue Shield United of Wisconsin (BCBSUW) Medicare Plus $100,000 mainly involves a reduction in premium because MEDICARE will be paying a substantial portion of the health care costs. All plans are excellent, but there will be some additions and some loss in BENEFITS. The following are general examples of those differences.

ITEM	**BCBSUW Standard/ Standard II/SMP**	**BCBSUW Medicare Plus $100,000**
Deductible	Standard/SMP: $25/person/year for Major Medical Standard II: $300 person/year for Major Medical (Maximum of 2 deductibles per family per year)	No Deductible
Benefits	Benefits are paid @ either 100%, 80% or 50% de-pending on type of services/supply	Almost all benefits are paid @ 100%

Comparison To Other State Plans to Medicare Plus $100,000 (cont.)

ITEM	BCBSUW Standard/ Standard II/SMP	BCBSUW Medicare Plus $100,000
Routine Physical Exam	Benefit	No Benefit
Psychiatric Care (other than inpatient)	Major Medical @ 90% up to $2,000 annual maximum Standard II: 90% of first $2,000/yr	Limited to 90% of the 1st $2,000 each calendar yr. (Including Medicare's payment)

DEFINITIONS

There are a number of important terms which have special meaning when they are used in the CONTRACT and in this handbook. The most important of these terms and their definitions are listed here.

ANNUITANT means any retired EMPLOYEE of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System; or an EMPLOYEE with 20 years of creditable service or a disability benefit under Wis. Stats.§ 40.65.

BENEFIT PERIOD means the total duration of CONFINEMENTS that are separated from each other by less than 365 days.

BENEFITS means payments for HOSPITAL SERVICES, PROFESSIONAL SERVICES and OTHER SERVICES.

BIOLOGICALS means complex substances or products of organic or synthetic origin, other than food, depending for their action on the processes effecting immunity when used in immunization against or diagnosis and treatment of disease or obtained or standardized by biological methods. Some examples are vaccines, serums, antigens or insulin.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN (BCBSUW) means a service insurance corporation organized under Chapter 613 of the Wisconsin State Statutes. For the purpose of the administration of the CONTRACT, BCBSUW is the agent of the BOARD. BCBSUW acts as health claim administrator under the terms of an Administrative Services Agreement with the State of Wisconsin.

Definitions (cont.)

BOARD means the Group Insurance Board.

BONE MARROW TRANSPLANTATION means the mixing of blood and bone marrow from a PARTICIPANT or a compatible donor by means of multiple bone punctures performed under anesthesia and transplanted to the recipient.

CALENDAR YEAR means the period that starts with a PARTICIPANT'S initial EFFECTIVE DATE of coverage under the CONTRACT and ends on December 31 of such year. Each following CALENDAR YEAR shall start on January 1 of any year and end on December 31 of that year.

CHARGE means an amount for a service or supply provided by a health care provider that is reasonable, as determined by BCBSUW, when taking into consideration, among other factors determined by BCBSUW, amounts charged by health care providers for similar services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care provider as full payment for similar services and supplies. In some cases the amount BCBSUW determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the service or supply. CHARGE includes all taxes for which a SUBSCRIBER can legally be charged, including but not limited to, sales tax.

COMPLICATION OF PREGNANCY means a condition needing medical treatment before or after termination of pregnancy. The condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis; cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems;

and similar conditions that can't be classified as a distinct COMPLICATION OF PREGNANCY but are connected with management of a difficult pregnancy. Also included are: terminated ectopic pregnancy, spontaneous termination that occurs during a pregnancy in which a viable birth is impossible, hyperemesis gravidarium, and preeclampsia.

CONFINEMENT means the period starting with a PARTICIPANT'S admission on an INPATIENT basis to a GENERAL HOSPITAL, SPECIALTY HOSPITAL, LICENSED SKILLED NURSING FACILITY or EXTENDED CARE FACILITY for treatment of an ILLNESS or INJURY. CONFINEMENT ends with the PARTICIPANT'S discharge from the same HOSPITAL or other facility.

CONGENITAL means a condition which exists at birth but is not hereditary.

CONTRACT means the Group Master Administrative Services Only Contract between the BOARD and Blue Cross and Blue Shield United of Wisconsin.

CUSTODIAL CARE means care given to a PARTICIPANT if he/she, as determined by BCBSUW:

a. is mentally or physically disabled; and
b. needs a protected, monitored and/or controlled environment; and
c. needs help to support the essentials of daily living; and
d. isn't under active and specific medical surgical and/or psychiatric treatment which will reduce the disability to the extent necessary for the PARTICIPANT to function outside a protected, monitored and/or controlled environment.

Definitions (cont.)

Care may still be considered CUSTODIAL CARE as determined by BCBSUW, even if:

a. the PARTICIPANT is under the care of a PHYSICIAN;

b. the PHYSICIAN prescribes services to support and maintain the PARTICIPANT'S condition; or

c. services and supplies are being provided by a registered nurse or licensed practical nurse.

DEPARTMENT means the Department of Employee Trust Funds.

DEPENDENT means the spouse of the SUBSCRIBER and his or her unmarried children (including legal wards who become legal wards of the SUBSCRIBER prior to age 19, but not temporary wards, adopted children or children placed for adoption as provided for in Wis. Stats.§ 632.896, and stepchildren), who are DEPENDENT on the SUBSCRIBER (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a DEPENDENT for federal income tax purposes (whether or not the child is claimed), and children of those DEPENDENT children until the end of the month in which the DEPENDENT child turns age 18. Children born outside of marriage become DEPENDENTS of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health and Family Services or equivalent if the birth was outside the State of Wisconsin. The EFFECTIVE DATE of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. A spouse and stepchildren cease to be DEPENDENTS at the end of the month in which a divorce decree is entered. Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards. Other children cease to be DEPENDENTS at the end of the CALENDAR YEAR in which they turn 19 years of age or cease to be DEPENDENT for support and maintenance, or at

Definitions (cont.)

the end of the month in which they marry, whichever occurs first, except that:

a. Children age 19 or over who are full-time students, if otherwise eligible, cease to be DEPENDENTS at the end of the CALENDAR YEAR in which they cease to be full-time students or in which they turn age 25, whichever occurs first.

b. Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in an institution which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, the term "school" includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools, and night schools.

c. If otherwise eligible children are, or become, incapable of self-support on account of a physical or mental disability which can be expected to be of long-continued or indefinite duration, they continue to be or resume their status of DEPENDENTS regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible DEPENDENT under this program in order to resume coverage. The plan will monitor mental or physical disability at least annually and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the initial plan determination.

Definitions (cont.)

d. A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

e. Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of eligibility, not on the date of notification to the plan.

DURABLE MEDICAL EQUIPMENT means an item which can withstand repeated use and is, as determined by BCBSUW:

a. primarily used to serve a medical purpose with respect to an ILLNESS or INJURY;

b. generally not useful to a person in the absence of an ILLNESS or INJURY;

c. appropriate for use in the PARTICIPANT'S home; and

d. prescribed by a PHYSICIAN.

All requirements of this definition must be satisfied before an item can be considered to be DURABLE MEDICAL EQUIPMENT.

EFFECTIVE DATE means the date, as certified by the DEPARTMENT and shown on the records of the BCBSUW on which a PARTICIPANT becomes entitled to the BENEFITS specified in this CONTRACT.

EMERGENCY means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson to reasonably conclude that a lack of medical attention will likely result in any of the following:

1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.

Definitions (cont.)

2. Serious impairment to the Participant's bodily functions.
3. Serious dysfunction of one or more of the Participant's body organs or parts.

EMPLOYEE means an eligible EMPLOYEE of the State of Wisconsin as defined under Wis. Stats.§ 40.02(25), or an eligible EMPLOYEE as defined under Wis. Stats. § 40.02 (46) or 40.19 (4) (a), of an EMPLOYER as defined under Wis. Stats. § 40.02 (28), other than the state, which has acted under Wis. Stats. § 40.51 (7), to make health care coverage available to its EMPLOYEES.

EMPLOYER means the employing state agency or participating local government.

EXPERIMENTAL/INVESTIGATIVE means the use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY, as determined by BCBSUW:

a. requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or
b. isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY, as determined by BCBSUW.
c. The criteria that BCBSUW uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL/INVESTIGATIVE include, but are not limited to:
    1) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis;

Definitions (cont.)

2) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States;
3) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply;
4) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT;
5) whether the service, treatment, procedure, facility, equipment, drug, device or supply is MEDICALLY NECESSARY;
6) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, Medicaid and other insurers and self-funded plans.

EXTENDED CARE FACILITY means a convalescent or chronic disease facility, whether operated independently or as a part of a GENERAL HOSPITAL which is accredited by the Joint Commission on Accreditation of Hospitals, or is recognized as an EXTENDED CARE FACILITY under MEDICARE or which is a nursing home as defined in Wis. Stats. § 50.01 (3). The term excludes facilities providing services primarily for custodial or domiciliary care or for the care of drug addiction or alcoholism.

Definitions (cont.)

EXTENDED CARE SERVICES means those services defined under MEDICARE and covered by MEDICARE in a MEDICARE certified EXTENDED CARE FACILITY which include: SKILLED NURSING CARE; accommodations provided in connection with the furnishing of SKILLED NURSING CARE; physical, occupational or speech therapy furnished or arranged by the EXTENDED CARE FACILITY; medical social services; PRESCRIPTION DRUGS and BIOLOGICALS (including whole blood and packed red blood cells) which are determined by BCBSUW to be medically recognized as being used in the treatment of an ILLNESS or INJURY; MEDICAL SUPPLIES, appliances and DURABLE MEDICAL EQUIPMENT used in and furnished by the EXTENDED CARE FACILITY for the care and treatment of INPATIENTS; MEDICAL SERVICES of interns and residents-in-training under an approved teaching program of a HOSPITAL with which the facility has in effect a transfer agreement; and other diagnostic or therapeutic services and supplies provided by a HOSPITAL with which the EXTENDED CARE FACILITY has in effect a transfer agreement.

GENERAL HOSPITAL means an institution which is licensed as a HOSPITAL which is accredited by the Joint Commission on Accreditation of Hospitals providing 24 hour continuous service to confined patients. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons. A professional staff of PHYSICIANS and surgeons must provide or supervise its services. It must provide GENERAL HOSPITAL and major surgical facilities and services. It can't be:

(a.)a convalescent or EXTENDED CARE FACILITY unit within or affiliated with the HOSPITAL;

(b.)a clinic;

Definitions (cont.)

(c.) a nursing, rest or convalescent home, or EXTENDED CARE FACILITY;

(d.) an institution operated mainly for care of the aged or for treatment of mental disease, drug addiction or alcoholism; or

(e.) a health resort, spa or sanitarium.

GRAFTING means the implanting or transplanting of any tissue or organ.

HEALTH BENEFIT PLAN means the part of this CONTRACT that provides BENEFITS for health care expenses, as described in Sections I through XVI in the State of Wisconsin Group Insurance Board Health Benefit Plan.

HOME CARE means a program providing HOME CARE services to a PARTICIPANT after discharge from CONFINEMENT in a HOSPITAL, as a substitute for CONFINEMENT. It means a program participated in by BCBSUW, the attending PHYSICIANS, various visiting nurse associations and/or organizations and various HOSPITALS to make HOME CARE services available to PARTICIPANTS, who may, in the judgment of the PARTICIPANT'S PHYSICIAN, be discharged from CONFINEMENT earlier than would otherwise be medically advisable. The HOME CARE services must be provided or coordinated by a state licensed or MEDICARE certified home health agency or certified rehabilitation agency.

HOSPICE CARE means services provided to a terminally ill PARTICIPANT outside of a HOSPITAL or EXTENDED CARE FACILITY in order to ease pain and to make a PARTICIPANT as comfortable as possible. HOSPICE CARE services must be provided by or coordinated by a MEDICARE certified HOSPICE CARE facility under a HOSPICE CARE program.

Definitions (cont.)

HOSPITAL means a GENERAL HOSPITAL, as defined above.

HOSPITAL SERVICES means ROOM ACCOMMODATIONS and all services, equipment, medications and supplies that are furnished, provided by and used in the HOSPITAL, SPECIALTY HOSPITAL or EXTENDED CARE FACILITY to which the PARTICIPANT is admitted as a registered patient.

ILLNESS means a bodily disorder, disease, pregnancy, COMPLICATION OF PREGNANCY or NERVOUS OR MENTAL DISORDER. All ILLNESS existing simultaneously are considered one ILLNESS. Successive periods of ILLNESS due to the same or related causes are considered one ILLNESS. An ILLNESS is deemed terminated:

(a.) in the case of a SUBSCRIBER, upon the resumption of all duties of his/her occupation on a full time basis for at least 30 consecutive days.

(b.) in the case of a DEPENDENT, upon the resumption in full of normal activities for at least 30 consecutive days.

(c.) in any event, when, after a PARTICIPANT receives any medical or HOSPITAL treatment or care (whether or not payable under the CONTRACT), a period of at least 30 consecutive days intervenes before the PARTICIPANT again receives treatment or care.

IMMEDIATE FAMILY means the SUBSCRIBER'S spouse, children, parents, grandparents, brothers and sisters and their own spouses.

IMPLANTATION means the insertion of an organ, tissue, prosthetic or other device in the body.

INJURY means bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes.

Definitions (cont.)

INPATIENT means a PARTICIPANT admitted as a bed patient to a health care facility.

LICENSED SKILLED NURSING FACILITY means a skilled nursing facility licensed as a skilled nursing facility by the state in which it is located. The facility must be staffed, maintained and equipped to provide these skilled nursing services continuously: observation and assessment; care; restorative and activity programs. These must be under professional direction and medical supervision as needed.

MAINTENANCE THERAPY means ongoing therapy delivered after the acute phase of an illness has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Therapy" is made by BCBSUW after reviewing an individual's case history or treatment plan submitted by a provider.

MEDICALLY NECESSARY means a service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, PHYSICIAN or other health care provider that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by BCBSUW:

(a.) consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY;

(b.) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY;

(c.) not solely for the convenience of the PARTICIPANT, PHYSICIAN, HOSPITAL or other health care provider; and

Definitions (cont.)

(d.)the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

MEDICAL SERVICES means PROFESSIONAL SERVICES recognized by doctors of medicine in the treatment of ILLNESS or INJURY. Not included are: maternity services; surgery; anesthesiology; pathology; and radiology.

MEDICAL SUPPLIES means items which are:

(a.)primarily used to treat an ILLNESS or INJURY;

(b.)generally not useful to a person in the absence of an ILLNESS or INJURY;

(c.)the most appropriate items which can safely be provided to a PARTICIPANT and accomplish the desired end result in the most economical manner; and

(d.)prescribed by a PHYSICIAN. The item's primary function must not be for comfort or convenience.

MEDICARE means BENEFITS available under Title XVIII of the Social Security Act of 1965, as amended.

NERVOUS OR MENTAL DISORDER means any condition classified as a neurosis, psychoneurosis, psychopathy or psychosis.

ORAL SURGERY means an operative procedure to correct a problem in the oral cavity.

OTHER COVERAGE means any group or franchise CONTRACT, policy, plan or program of prepaid service care or insurance arranged through any EMPLOYER, trustee, union or association including, but not limited to, disability, health and accident or sickness care coverage, or the medical payments provisions of an automobile insurance

policy, any or all of which would provide BENEFITS for medical care of any nature either on a service or expense incurred basis if the CONTRACT was not in effect.

OTHER SERVICES means those services, if any, specified in the CONTRACT other than HOSPITAL SERVICES and PROFESSIONAL SERVICES.

OUTPATIENT means a PARTICIPANT who is admitted as a non-bed patient to receive HOSPITAL SERVICES.

PARTICIPANT means a SUBSCRIBER, or any of his/her DEPENDENTS, eligible for MEDICARE for whom proper application for Medicare Plus $100,000 coverage has been made and for whom the appropriate Premium has been paid.

PHYSICIAN means a licensed medical doctor or surgeon. When required by law to cover the services of any other licensed medical professional under the CONTRACT, a PHYSICIAN also includes such other licensed medical professional (for example, a chiropodist, podiatrist, dentist or chiropractor) who:

(a.)is acting within the lawful scope of his/her license; and

(b.)performs a service which would be payable under the CONTRACT.

PRESCRIPTION DRUG means drugs that are dispensed by a written prescription from a PHYSICIAN, under Federal law, approved for human use by the Food and Drug Administration and dispensed by a licensed pharmacist.

PROFESSIONAL SERVICES means services provided by a PHYSICIAN of the PARTICIPANT'S choice to treat his/her ILLNESS or INJURY. Such services include services provided by a registered or licensed practical nurse, laboratory/x-ray technician and physician assistant provided such person is lawfully employed by the supervising

PHYSICIAN or the facility where the service is provided, and he/she provides an integral part of the supervising PHYSICIAN'S PROFESSIONAL SERVICES while the PHYSICIAN is present in the facility where the service is provided. With respect to such services provided by a registered nurse or licensed practical nurse, laboratory/x-ray technician and physician assistant, such services must be billed by the supervising PHYSICIAN or the facility where the service is provided.

ROOM ACCOMMODATIONS means bed and room including nursery care, meals and dietary services and general nursing services provided to an INPATIENT.

SKILLED NURSING CARE means care furnished on a PHYSICIAN'S orders which requires the skills of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the supervision of these personnel.

SMP means State Maintenance Plan

SPECIALTY HOSPITAL means a short-term SPECIALTY HOSPITAL approved by BCBSUW and the State, licensed and accepted by the appropriate state or regulatory agency to provide diagnostic services and treatment for patients who have specified medical conditions. Such short-term SPECIALTY HOSPITALS include, for example, psychiatric, alcoholism and drug abuse, orthopedic and rehabilitative HOSPITALS.

SPELL OF ILLNESS means the total duration of all successive CONFINEMENTS that are separated from each other by less than 60 days.

STANDARD PLAN means the HEALTH BENEFIT PLAN excluding STANDARD PLAN II, SMP, WISCONSIN PUBLIC EMPLOYERS and Medicare Plus $100,000 coverage.

Definitions (cont.)

SUBSCRIBER means an EMPLOYEE or ANNUITANT eligible for MEDICARE for whom proper application for Medicare Plus $100,000 coverage has been made and for whom the appropriate PREMIUM has been paid.

TRANSITIONAL TREATMENT ARRANGEMENTS means services for the treatment of NERVOUS OR MENTAL DISORDERS, alcoholism or drug abuse that are provided to a PARTICIPANT in a less restrictive manner than are INPATIENT HOSPITAL SERVICES but in a more intensive manner than are OUTPATIENT services, if both the program and the facility are approved by the Department of Health and Family Services as defined in the Wis. Admin. Code, § 3.37, as amended. Such Transitional Treatment includes:

(a.) mental health services for adults in a day treatment program offered by a provider certified by the Department of Health and Family Services under the Wis. Admin. Code, § HFS 61.75;

(b.) mental health services for children and adolescents in a day treatment program offered by a provider certified by the Department of Health and Family Services under the Wis. Admin. Code, § HFS 61.81;

(c.) services for persons with chronic mental ILLNESS provided through a community support program certified by the Department of Health and Family Services under the Wis. Admin. Code, § HFS 63.03;

(d.) residential treatment programs for alcohol and drug dependent persons certified by the Department of Health and Family Services under the Wis. Admin. Code, § HFS 61.60;

(e.) services for alcoholism and other drug problems provided in a day treatment program certified by the Department of Health and Family Services under the Wis. Admin. Code, § HFS 61.61;

Definitions (cont.)

(f.) intensive OUTPATIENT programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine; and

(g.)out of state services and programs that are substantially similar to (a), (b), (c), (d) and (e) if the provider is in compliance with similar requirements of the state in which the health care provider is located.

TRANSPLANTATION means GRAFTING of tissue or organ, including parts or substances from the same body or from another body.

MEDICARE PLUS $100,000 PROGRAM

The Medicare Plus $100,000 plan is designed to supplement, not duplicate, BENEFITS available under the Federal MEDICARE plan. It is designed for ANNUITANTS and their DEPENDENTS and is not available to active EMPLOYEES or their DEPENDENTS.

All persons must enroll for MEDICARE - both Part A HOSPITAL and Part B Medical - when first eligible. Otherwise, by statute, your state group health coverage is subject to cancellation without reinstatement. (This provision is delayed only for active EMPLOYEES, their spouses and their DEPENDENT children, until the SUBSCRIBER terminates state employment.)

MEDICARE becomes available at age 65, or after Social Security disability BENEFITS have been received for 24 months, or for those who have chronic kidney disease.

Your Medicare Plus $100,000 coverage will terminate under the following conditions:

- If you decide to cancel your Medicare Plus $100,000 coverage while still a State of Wisconsin ANNUITANT, you must submit a written signed request to the Department of Employee Trust Funds.
- If your Medicare Plus $100,000 contract terminates for any reason other than voluntary cancellation, BENEFITS will continue for any condition, disease, ailment or INJURY previously covered by the CONTRACT. This extension will be effective until the end of the SPELL OF ILLNESS, which is defined as the total duration of all CONFINEMENTS that are separated from each other by less than 60 days.

Medicare Plus $100,000 Program (cont.)

- If your eligibility for inclusion under the State of Wisconsin's group health plan ceases, your Medicare Plus $100,000 group coverage will be null and void on the last day of the same month. You may than continue coverage by making payment directly to BCBSUW for the BCBSUW conversion contract then being issued. Continuous coverage depends on fulfillment of the direct pay contract requirements, conditions and premium rates.
- Failure to pay premiums timely when billed will result in cancellation of coverage with no opportunity to reinstate.

This booklet briefly describes benefit provisions. Additional information may be obtained from:

- State EMPLOYEES health insurance booklet - "Standard and SMP Plans Group Health Insurance" or "STANDARD PLAN II", both published for the Department of Employee Trust Funds by BCBSUW.
- "Your MEDICARE Handbook" published by the Social Security Administration.
- "It's Your Choice" brochure published every October by the Department of Employee Trust Funds.

BENEFITS AVAILABLE

Except as excluded in the CONTRACT, BENEFITS are payable for CHARGES for the following services and supplies on or after the EFFECTIVE DATE according to the terms, conditions and provisions of the CONTRACT, if those services and supplies are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by BCBSUW.

A. Inpatient Hospital Services

HOSPITAL SERVICES for other than Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS are payable at 100% of the CHARGES for a maximum of 120 days during any one SPELL OF ILLNESS less the number of days specified under MEDICARE for INPATIENT HOSPITAL SERVICES.

However, if the PARTICIPANT occupies a private room, CHARGES for ROOM ACCOMMODATIONS are limited to the HOSPITAL'S average regular per diem CHARGES for all of its two-bed ROOM ACCOMMODATIONS.

B. Outpatient Hospital Services

HOSPITAL SERVICES for an OUTPATIENT are payable at 100% of the CHARGES for:

1. First aid emergency care;
2. Surgical procedures;
3. X-ray or laboratory examinations; and
4. X-ray, radium and radioactive isotope therapy.

Benefits Available (cont.)

C. Extended Care Services in a Licensed Skilled Nursing Facility

BENEFITS are payable for CHARGES for INPATIENT EXTENDED CARE SERVICES if:

1. A PARTICIPANT receives care in a MEDICARE approved EXTENDED CARE FACILITY and remains under continuous active medical supervision provided the PARTICIPANT was a HOSPITAL INPATIENT for at least three days prior to CONFINEMENT in an EXTENDED CARE FACILITY; or
2. A PARTICIPANT receives care in a Non-MEDICARE approved EXTENDED CARE FACILITY and remains under continuous active medical supervision;
    a. If transferred 24 hours of release from a HOSPITAL, the CONTRACT will pay the maximum daily rate established for SKILLED NURSING CARE in that facility by the Department of Health and Family Services for purposes of reimbursement under the Medical Assistance Program under Wis. Stats.§ 49.45 to 49.47, BENEFITS are payable for such care at that facility up to 30 days per CONFINEMENT. BENEFITS are payable only if the attending PHYSICIAN certifies that the SKILLED NURSING CARE is MEDICALLY NECESSARY. The PHYSICIAN must recertify this every seven days. BENEFITS are not payable for essentially domiciliary or CUSTODIAL CARE, or care which is available to the PARTICIPANT without CHARGE or under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes). CHARGES for days 31-100 of CONFINEMENT during a SPELL OF ILLNESS are limited to $50.00

per day. All covered services thereafter. CUSTODIAL CARE as defined is not covered.

b. If transferred within 14 days following CONFINEMENT of at least three consecutive days in a HOSPITAL, CHARGES for the first 100 days of CONFINEMENT during a SPELL OF ILLNESS are limited to $50.00 per day. All covered services thereafter. CUSTODIAL CARE as defined is not covered.

D. Professional Services and Other Services

Except as otherwise specifically provided, BENEFITS for CHARGES for PROFESSIONAL SERVICES and OTHER SERVICES are payable at 100% of the CHARGES for:

1. Cataract lenses following cataract surgery.
2. Chemotherapy
3. INPATIENT private duty skilled nursing services.
4. ORAL SURGERY services and associated diagnostic x-rays, but excluding extraction of teeth other than by surgery, root canal procedures, dental implants, filling, capping, recapping or other routine repair or maintenance of teeth. ORAL SURGERY services include total extraction or total replacement of natural teeth when necessitated by an INJURY. Services must occur while the PARTICIPANT is entitled to BENEFITS. A dental repair method, other than extraction and replacement, may be considered if approved by BCBSUW before the service is performed.
5. Coverage includes pharmacological products that by law require a written prescription and are prescribed by a PHYSICIAN for the purpose of achieving smoking cessation (i.e., Zyban, nicotine inhaler spray or patch).

Benefits Available (cont.)

These are subject to the prescription drug copayment and annual out-of-pocket maximum. Limited to a maximum of one three-month course of pharmacotherapy per calendar year. Coverage also includes one office visit for counseling and to obtain the prescription. Additional counseling may be authorized by BCBSUW. Over the counter products will not be covered.

6. CHARGES for BIOLOGICALS, and drugs administered during an office visit with a PHYSICIAN for treatment of an ILLNESS or INJURY are paid at 80%.
7. CHARGES for PRESCRIPTION DRUGS and BIOLOGICALS prescribed in writing by a PHYSICIAN for treatment of an ILLNESS or INJURY and dispensed by a licensed pharmacist are subject to a copayment of $5.00 for a generic drug or $10.00 for a brand drug per prescription or refill. Covered PRESCRIPTION DRUGS are paid at 100% after the annual out-of-pocket maximum of $240.00 per individual or $480.00 for two or more individuals covered by Medicare is met. PRESCRIPTION DRUG coverage also includes oral contraceptives.
8. Physical, speech and occupational therapy when necessitated by an ILLNESS or INJURY, by a registered physical, speech or occupational therapist other than one who ordinarily resides in the PARTICIPANT’S home or who is a member of the PARTICIPANT’S family, when recommended by a PHYSICIAN.
9. Oxygen and rental of equipment for its administration.

Benefits Available (cont.)

10. Professional licensed ambulance service necessary to transport a PARTICIPANT to or from a HOSPITAL. Services include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance service is unavailable and such transportation is substantiated by a PHYSICIAN as being MEDICALLY NECESSARY.
11. Treatment of Temporomandibular Disorders

    Covers diagnostic procedures and prior authorized Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

    a. A CONGENITAL, developmental or acquired deformity, disease or injury caused the condition.
    b. The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care provider rendering the service.
    c. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

    This includes coverage of non-surgical treatment, including intraoral splint therapy, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Benefits for diagnostic procedures and non-surgical treatment will be payable up to $1,250.00 per contract year.
12. MEDICAL SUPPLIES prescribed by a PHYSICIAN. BENEFITS are payable only if BCBSUW approves the supply as being appropriate for a PARTICIPANT’S medical condition.

Benefits Available (cont.)

13. Rental of or, at the option of BCBSUW, purchase of DURABLE MEDICAL EQUIPMENT such as, but not limited to: wheelchairs, hospital-type beds and artificial respiration equipment. When the equipment is purchased, BENEFITS are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance and replacement of batteries are not covered.
14. OUTPATIENT cardiac rehabilitation services. Services must be approved by BCBSUW and provided in an OUTPATIENT department of a HOSPITAL, in a medical center or clinic program. This benefit applies only to PARTICIPANTS with a recent history of:
    - a heart attack (myocardial infarction);
    - coronary bypass surgery;
    - onset of angina pectoris;
    - heart valve surgery;
    - onset of decubital angina;
    - onset of unstable angina; or
    - percutaneous transluminal angioplasty.

    BENEFITS are payable only for PARTICIPANTS who begin an exercise program immediately following their HOSPITAL CONFINEMENT for one of the conditions shown above. BENEFITS are limited to CHARGES for three sessions per week for 26 weeks beginning with the first session in the OUTPATIENT exercise program.

    BENEFITS are not payable for behavioral or vocational counseling. A new BENEFIT PERIOD is available following a subsequent period of hospitalization for any of the conditions listed in this paragraph. No other BENEFITS for OUTPATIENT

cardiac rehabilitation services are available under the CONTRACT.

E. Home Care

1. Benefits.

   This subsection applies only if CHARGES for HOME CARE services are not covered elsewhere under the CONTRACT. A Department licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the services. A PARTICIPANT should make sure the agency meets this requirement before services are provided. BENEFITS are payable for CHARGES for the following services when MEDICALLY NECESSARY for treatment:

   a. Part-time or intermittent home nursing care by or under supervision of a registered nurse;
   b. Part-time or intermittent home health aide services when MEDICALLY NECESSARY as part of your HOME CARE plan. The services must consist solely of care for you. A registered nurse or medical social worker must supervise them;
   c. Physical, respiratory, occupational or speech therapy;
   d. MEDICAL SUPPLIES, PRESCRIPTION DRUGS and BIOLOGICALS and medications prescribed by a PHYSICIAN; laboratory services by or on behalf of a HOSPITAL, if needed under the HOME CARE plan. These items are covered to the extent they would be if the PARTICIPANT had been hospitalized;
   e. Nutrition counseling provided or supervised by a registered dietician;

Benefits Available (cont.)

f. Evaluation of the need for a HOME CARE plan by a registered nurse, PHYSICIAN extender or medical social worker. The PARTICIPANT'S attending PHYSICIAN must request or approve this evaluation.

F. Limitations

The following limits apply to HOME CARE services:

1. HOME CARE isn't covered unless the PARTICIPANT'S attending PHYSICIAN certifies that:
   - Hospitalization or CONFINEMENT in a LICENSED SKILLED NURSING FACILITY would be needed if the PARTICIPANT didn't have HOME CARE; and
   - Members of the PARTICIPANT'S IMMEDIATE FAMILY or others living with the PARTICIPANT couldn't give the PARTICIPANT the care and treatment he/she needs without undue hardship;
2. If the PARTICIPANT was hospitalized just before HOME CARE started, the PARTICIPANT'S PHYSICIAN during his/her HOSPITAL stay must also approve the HOME CARE plan;
3. BENEFITS are payable for CHARGES for up to 365 HOME CARE visits in any 12 month period per PARTICIPANT. Each visit by a person providing services under a HOME CARE plan, evaluating the PARTICIPANT'S need or developing a plan counts as one visit. Each period of up to 4 straight hours in a 24-hour period of home health aide service counts as one HOME CARE visit.
4. If HOME CARE is covered under two or more health insurance contracts or plans, coverage is payable under only one of them. The same is true if the PARTICIPANT has HOME CARE coverage under the CONTRACT and another source;

Benefits Available (cont.)

5. The maximum weekly benefit for this coverage won't be more than weekly CHARGES for SKILLED NURSING CARE in a LICENSED SKILLED NURSING FACILITY, as determined by BCBSUW.

G. Hospice Care Services

1. BENEFITS are payable for CHARGES for the following HOSPICE CARE services:
   a. Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
   b. Part-time or intermittent home health services when MEDICALLY NECESSARY. Such services must be under the supervision of a registered nurse or medical social worker and consist solely of care for the PARTICIPANT.
   c. Physical, respiratory, occupational or speech therapy;
   d. MEDICAL SUPPLIES, prescription drugs and BIOLOGICALS and medications prescribed by a PHYSICIAN; laboratory services by or on behalf of a HOSPITAL, to the extent CHARGES would be payable for these items under the CONTRACT if the PARTICIPANT had been hospitalized;
   e. Nutrition counseling provided or supervised by a registered nurse, PHYSICIAN extender or medical social worker, when approved or requested by the attending PHYSICIAN; and
   f. Room and board CHARGES at a BCBSUW approved or MEDICARE certified HOSPICE CARE facility.

Benefits Available (cont.)

CHARGES for weekly HOSPICE CARE services are payable up to the weekly CHARGES for SKILLED NURSING CARE provided in an EXTENDED CARE FACILITY, as determined by BCBSUW.

2. Limitations for HOSPICE CARE services

   BENEFITS for HOSPICE CARE services are limited as follows:

   a. HOSPICE CARE is not covered unless the PARTICIPANT'S attending PHYSICIAN certifies that:

      1) hospitalization or CONFINEMENT would otherwise be required;

      2) necessary care and treatment care not available from members of the PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT; and

      3) the PARTICIPANT is terminally ill with a life expectancy of six months or less.

   b. CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a MEDICARE certified or BCBSUW approved HOSPICE CARE facility.

      CHARGES are payable for HOSPICE CARE services provided in a PARTICIPANT'S home up to 80 HOSPICE CARE visits within any six month period.

      Up to four consecutive hours of HOSPICE CARE services in a PARTICIPANT'S home is considered as one HOSPICE CARE visit. CHARGES which qualify for payment under this section and/or HOME CARE are charged against the benefit limits of this section.

BENEFITS FOR TREATMENT OF ALCOHOLISM, DRUG ABUSE OR NERVOUS OR MENTAL DISORDERS

Total BENEFITS payable under A., B. and C. below shall not exceed the annual maximum amount of $7,000.00 per PARTICIPANT per CALENDAR YEAR.

A. Inpatient Hospital Services

This section applies to those PARTICIPANTS admitted as resident patients for treatment of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable at 100% after MEDICARE's payment up to the lesser of the CHARGES for the first 120 days or the first $6,300.00 in CHARGES each CALENDAR YEAR.

HOSPITAL SERVICES are not to exceed 365 days of CONFINEMENT throughout a PARTICIPANT'S lifetime while the PARTICIPANT is covered under the CONTRACT following the EFFECTIVE DATE.

B. Outpatient Hospital Services

Treatment of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS for a PARTICIPANT other than as an INPATIENT is limited to the initial $100.00 Deductible and the amount which combined with the MEDICARE benefit equals 90% of the first $2,000.00 in CHARGES during any CALENDAR YEAR.

Such treatment services must be provided by a PHYSICIAN, a licensed psychologist who is listed in the National Register of Health Service Providers in Psychology, a facility established and maintained according to rules promulgated under Wis. Stats. §

51.42(7)(b), or a medical clinic or billed by a psychologist under the direction of a PHYSICIAN.

C. Transitional Treatment Arrangements

Transitional Treatment is limited to the initial $100.00 Deductible and the amount which combined with the MEDICARE benefit equals 90% of the first $3,000.00 in CHARGES during any CALENDAR YEAR.

The criteria that the BCBSUW uses to evaluate a Transitional Treatment program or service to determine whether it is covered under the CONTRACT include, but are not limited to:

1. the program is certified by the Department of Health and Family Services;
2. the program meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;
3. the specific diagnosis is consistent with the symptoms;
4. the treatment is standard medical practice and appropriate for the specific diagnosis;
5. the treatment plan is focused for the specific diagnosis;
6. the multidisciplinary team running the program is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider’s program is located or the service is provided;
7. see the definition of “medically necessary” in the definitions.

Benefits for Treatment of Alcoholism, Drug Abuse or Nervous or Mental Disorders (cont.)

BCBSUW will need the following information from the health care provider to help BCBSUW determine the medical necessity of such program or service:

1. a summary of the development of the PARTICIPANT'S ILLNESS and previous treatment;
2. a well-defined treatment plan listing treatment objectives, goals and duration of the care provided under the transitional treatment arrangement program;
3. a list of credentials for the staff who participated in the transitional treatment arrangement program or service, unless the program or service is certified by the Department of Health and Family Services.

TRANSPLANTATIONS, IMPLANTATIONS AND GRAFTINGS

Except as otherwise specifically excluded in the CONTRACT, BENEFITS for CHARGES are payable for each PARTICIPANT receiving such services in connection with the BENEFITS described in this section on or after his/her EFFECTIVE DATE, if those services are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by BCBSUW, subject to all terms, conditions and provisions of the CONTRACT.

A. Transplantations

The following TRANSPLANTATIONS are covered by the CONTRACT:

1. Autologous (self to self) and allogenic (donor to self) BONE MARROW TRANSPLANTATIONS and peripheral blood stem cell rescue and/or TRANSPLANTATIONS used only in the treatment of:
   - Mydlodysplastic syndrome
   - Homozygous Beta-Thalassemia
   - Mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
   - Neuroblastoma
   - Multiple Myeloma, Stage II or Stage III
   - Germ Cell Tumors (e. g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

Transplantations, Implantations and Graftings (cont.)

- Aplastic anemia;
- Acute leukemia;
- Severe combined immunodeficiency, e.g., adenosine deaminase deficiency and idiopathic deficiencies;
- Wiskott - Aldrich syndrome;
- Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
- Hodgkins' and non-Hodgkins' lymphoma;
- Combined immunodeficiency;
- Chronic myelogenous leukemia;
- Pediatric tumors based upon individual consideration.

2. Parathyroid TRANSPLANTATION.
3. Musculoskeletal TRANSPLANTATIONS intended to improve the function and appearance of any body area which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.
4. Corneal TRANSPLANTATION (keratoplasty) limited to:
   - Corneal opacity;
   - Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens;
   - Corneal ulcer;
   - Repair of severe lacerations.
5. Kidney.

Transplantations, Implantations and Graftings (cont.)

B. Implantations.

The following IMPLANTATIONS are covered by the CONTRACT:

1. Heart valve IMPLANTATION;
2. Pseudophakia (intracular lens) IMPLANTATION;
3. Penile prosthesis IMPLANTATION;
4. Urethal sphincter IMPLANTATION;
5. Artificial breast IMPLANTATION.

C. Graftings.

The following GRAFTINGS are covered by the CONTRACT:

1. Bone (non-cosmetic);
2. Skin (non-cosmetic);
3. Artery;
4. Arteriovenous shunt;
5. Blood vessel limited to blood vessel repair;
6. Cartilage (non-cosmetic);
7. Conjunctiva;
8. Fascia;
9. Lid margin (non-cosmetic);
10. Mucosa;
11. Bronchoplasty;
12. Coronary bypass;
13. Mucus membrane;
14. Muscle;
15. Nerve;
16. Pterygium;

Transplantations, Implantations and Graftings (cont.)

17. Rectal (Thiersch operation);
18. Sclera;
19. Tendon;
20. Vein (bypass).

D. Exclusions.

BENEFITS are not payable for any form of or services related to TRANSPLANTATION, IMPLANTATION or GRAFTING other than those specifically listed in this section.

Examples of procedures that are **not payable:**

1. Heart TRANSPLANTATION;
2. Intestine TRANSPLANTATION;
3. Islet tissue (island of Langerhans-pancreas) TRANSPLANTATION;
4. Liver TRANSPLANTATION;
5. Lung TRANSPLANTATION;
6. Pancreas TRANSPLANTATION;
7. Bladder stimulator (pacemaker) IMPLANTATION;
8. Implantable or portable artificial kidney or other similar device; or
9. Dental implants.

Aggregate Lifetime Maximum Benefit Limit

The aggregate lifetime maximum benefit limit for BENEFITS paid for CHARGES for services and supplies covered under this section is $100,000 for an ILLNESS or INJURY of a PARTICIPANT during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the CONTRACT.

Transplantations, Implantations and Graftings (cont.)

If evidence satisfactory to BCBSUW is furnished that a PARTICIPANT has fully recovered from an ILLNESS or INJURY, the aggregate lifetime maximum benefit limit will be restored to $100,000.

OUTLINE OF COVERAGE
MEDICARE PLUS $100,000

Services or Supplies	Medicare Pays Per Benefit Period	Medicare + $100,000 Pays
Hospital Semi-private room and board and miscellaneous hospital services and supplies such as drugs, x-rays, lab tests and operating room	First 60 days - All but $792	Initial $792* deductible
	61st - 90th day All but $198 a day	$198* a day
	91st - 150th days -All but $396 a day (Lifetime Reserve)	$396* a day
Skilled Nursing Facility Medicare covered services in a Medicare Approved Facility**	Requires a 3-day period of hospital	Requires a 3-day period of hospital
	First 20 days - 100% of costs	Nothing
	21st-100th Days - All but $99.00 a day	$99.00* a day
	Beyond 100 days - Nothing	All covered services. Custodial care as defined is not covered.

*Federal Medicare deductibles are adjusted annually; figures shown here are for 2001. Medicare Plus $100,000 BENEFITS are also adjusted annually to pay these deductibles.

**Custodial Care as defined is not covered.

Outline of Coverage Medicare Plus $100,000 (cont.)

Services or Supplies	Medicare Pays Per Benefit Period	Medicare + $100,000 Pays
Skilled Nursing Facility*	Covers only the same type of expenses normally covered by Medicare in a Medicare Approved Facility	Covers only the same type of expenses normally covered by Medicare in a Medicare Approved Facility
(**Non**-Medicare Approved Facility) If admitted within 14 days following a hospital stay of at least 3 days	Nothing	$50/day for the 1st 100 days. All covered services. thereafter. (Note: if the patient is admitted within 24 hours after discharge from a general hospital, payment is made in full for all covered services during the first 30 days.)
Home Health Care- Under an approved plan of care, part-time services of an RN, LPN, or Home Health Aide; physical, respiratory, speech or occupational therapy; medical supplies, drugs, lab services and nutritional counseling	Generally 5 visits per week for 2 to 3 weeks; or 4 or fewer visits per week as long as required	Up to 365 visits per year

*Custodial Care as defined is not covered.

Outline of Coverage Medicare Plus $100,000 (cont.)

Services or Supplies	Medicare Pays Per Benefit Period	Medicare + $100,000 Pays
Hospice Care -Medicare certified program of terminal illness care for pain relief and symptom management. Includes: Nursing care; physician services; physical, occupational & speech therapy; social worker services; home health aids; homeworker services; medical supplies. 1st 180 days and any Medicare approved extension	All Covered Services	Nothing
Hospice Facility	Nothing	Up to the equivalent charges of a Skilled Nursing Facility
Miscellaneous Services Physical, speech and occupational therapy; ambulance service, prosthetic devices; durable medical equipment	After annual $100 Medicare deductible, 80% of allowable charges (Note: Maximum annual benefit for physical therapy is $900)	Initial $100 deductible and any reasonable charges not payable by Medicare

Outline of Coverage Medicare Plus $100,000 (cont.)

Services or Supplies	Medicare Pays Per Benefit Period	Medicare + $100,000 Pays
Physicians Services Excludes routine physical exams. Includes: Medical care, surgery, home and office calls, dental surgeons, anesthesiologists, etc.	After annual $100 Medicare deductible, 80% of allowable charges	Initial $100 deductible and any reasonable charges not payable by Medicare
Drugs and Biologicals (non-hospitalization) Self-administered drugs prescribed by a physician	After annual $100 Medicare deductible, 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant	Pharmacy dispensed prescription drugs subject to a $5.00 copay for generic drugs and a $10.00 copay for brand name or drugs to a maximum out of pocket of $240.00 per person and $480.00 for two or more individuals covered by Medicare.
Outpatient Hospital Services In an emergency room or outpatient clinic; diagnostic	After the annual $100 Medicare deductible, 80% of allowable charges	Initial $100 deductible and any reasonable charges not payable by Medicare

Outline of Coverage Medicare Plus $100,000 (cont.)

Services or Supplies	Medicare Pays Per Benefit Period	Medicare +$100,000 Pays
Outpatient Hospital Services (cont.)		
lab and x-ray tests; medical supplies such as casts, splints, and drugs which can not be self-administered		
Psychiatric Treatment Other than hospital inpatient	After the annual $100 Medicare deductible, 50% of allowable charges	Initial $100 deductible and the amount, which combined with the Medicare benefit equals 90% of the first $2,000 of reasonable charges
Private Duty Nurse (RN or LPN) While hospitalized	Nothing	100% of reasonable charges
Blood	After annual $100 Medicare deductible, 80% of costs except non-replacement fees (blood deductible) for 1st 3 pints in each benefit period	Initial $100 deductible and any reasonable charges not payable by Medicare

GENERAL EXCLUSIONS

Except as otherwise specifically provided, the CONTRACT provides no BENEFITS for:

1. CUSTODIAL CARE or rest cures, wherever furnished, care in custodial or similar institutions, a health resort, spa or sanitarium.
2. Services of a blood donor.
3. Treatment, services and supplies for cosmetic or beautifying purposes, except to correct CONGENITAL bodily disorders or conditions or when medically necessitated by an ILLNESS or accidental INJURY.
4. Eye glasses, contact lenses, hearing aids or examinations for their prescription.
5. Treatment of corns and calluses of the feet, toenails (except for complete removal), overgrowth of the skin of the feet, unless prescribed by a PHYSICIAN who is treating the PARTICIPANT for a metabolic or peripheral disease.
6. Services of a dentist, including all orthodontic services, or services provided in the examination, repair or replacement of teeth, or in the extraction of teeth, dental implants, or treatment for Temporomandibular Joint Disease (TMJ) other than recognized radical ORAL SURGERY, except as expressly provided in the CONTRACT. An accident caused by chewing is not considered an INJURY.
7. Treatment, services and supplies:
   a. that would be furnished to a PARTICIPANT without CHARGE;

General Exclusions (cont.)

b. which a PARTICIPANT would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or

c. which a PARTICIPANT would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if the CONTRACT was not in effect.

8. Treatment, services and supplies for any INJURY or ILLNESS eligible for coverage, or for which a PARTICIPANT receives, or which is the subject of, any award or settlement under a Worker's Compensation Act or any employer liability law.

9. Treatment, services and supplies for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or any State of the United States, or its Allies, or while serving in the Armed Forces of any country.

10. Treatment, services and supplies furnished by the U.S. Veterans Administration, except for such treatment, services and supplies for which under the CONTRACT, the CONTRACT is the primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.

11. Treatment, services and supplies available from OTHER COVERAGE. Then, BENEFITS will be limited to the CHARGES for treatment, services and supplies, less payments available from OTHER COVERAGE. Together, the total BENEFITS payable may not exceed the incurred CHARGES. In computing allowances available, the primary carrier according to Wis. Admin. Code § 3.40 will provide the

General Exclusions (cont.)

full BENEFITS payable under its contract, with the other carrier processing the remainder of those CHARGES. However, when MEDICARE is primary, payment of BENEFITS is limited to the amount computed without coordination of BENEFITS less the MEDICARE payments. MEDICARE allowed amount on assigned claims is considered the CHARGE; on unassigned claims, the CHARGE is the MEDICARE limiting CHARGE amount.

12. PROFESSIONAL SERVICES not provided by a PHYSICIAN.
13. Treatment, services and supplies which are not MEDICALLY NECESSARY or which aren't appropriate for the treatment of an ILLNESS or INJURY, as determined by BCBSUW.
14. Reversal of sterilization.
15. Treatment, services and supplies which are EXPERIMENTAL or INVESTIGATIVE in nature, except for PRESCRIPTION DRUGS and BIOLOGICALS described in Wis. Stats. § 632.895 (9) for treatment of HIV.
16. Treatment, services and supplies for, or leading to, sex transformation surgery and sex hormones related to such treatment.
17. Artificial insemination or fertilization methods including, but not limited to, in-vivo fertilization, in-vitro fertilization, embryo transfer, gamete intra-fallopian transfer (GIFT) and similar procedures, and related hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.
18. Treatment, services and supplies provided by a midwife.

General Exclusions (cont.)

19. Food received on an OUTPATIENT basis or food supplements.
20. Housekeeping, shopping or meal preparation services.
21. Treatment, services and supplies in connection with obesity, weight reduction or dietetic control, except for morbid obesity and disease etiology.
22. Retin-A, Minoxidil, Rogaine or their medical equivalent in the topical application form, unless MEDICALLY NECESSARY.
23. Treatment, services and supplies used in educational or vocational training.
24. Treatment, services and supplies in connection with any ILLNESS or INJURY caused by a PARTICIPANT'S:
    a. engaging in an illegal occupation; or
    b. commission of, or an attempt to commit, a felony.
25. Motor vehicles; lifts for wheelchairs and scooters; and stair lifts.
26. Treatment, services and supplies for which the PARTICIPANT has no obligation to pay.
27. Treatment, services and supplies rendered by a member of a PARTICIPANT'S family or a person who resides in the PARTICIPANT'S home.
28. Routine periodic maintenance of covered DURABLE MEDICAL EQUIPMENT, such as, replacement of batteries.
29. Immunizations, physical examinations or health checkups.

General Exclusions (cont.)

30. Any ROOM ACCOMMODATIONS, care, services, equipment, medications, devices, items or supplies if a PARTICIPANT is not entitled to any BENEFITS under MEDICARE.
31. Treatment, services and supplies determined to be MAINTENANCE THERAPY by BCBSUW.

GENERAL CONDITIONS

A. General Provisions

BENEFITS are available in accordance with the terms and conditions of the CONTRACT, including:

1. No provision of the CONTRACT shall interfere with the professional relationship between a PARTICIPANT and PHYSICIAN.
2. If a PARTICIPANT remains in an institution after advised by the attending PHYSICIAN that further CONFINEMENT is medically unnecessary, the SUBSCRIBER will be solely responsible to the institution for all expenses incurred after being so advised. BCBSUW or the BOARD may at any time request the attending PHYSICIAN to certify that further CONFINEMENT is MEDICALLY NECESSARY.
3. Each PARTICIPANT is free to select and/or discharge a PHYSICIAN. A PHYSICIAN is free to provide service or not, in accordance with the custom in the private practice of medicine. Nothing in the CONTRACT obligates BCBSUW or the BOARD to provide a PHYSICIAN to treat any PARTICIPANT.
4. Each PARTICIPANT agrees to conform to the rules and regulations of the institution in which he/she is an INPATIENT, including those rules governing admissions and types and scope of services furnished by the institution.
5. As a condition of entitlement to receive BENEFITS, each PARTICIPANT authorizes any person or institution to furnish to BCBSUW all medical and surgical reports and other information as BCBSUW may request.

General Conditions (cont.)

6. BCBSUW and the BOARD each have the right and opportunity to have a PARTICIPANT examined by PHYSICIANS of their choice when and as often as they may reasonably require.
7. The SUBSCRIBER'S identification card must be presented, or the fact of the SUBSCRIBER'S participation under the CONTRACT be made known, to the provider when the PARTICIPANT requests care or services.
8. If a PARTICIPANT fails to comply with 7. above, then written notice of the commencement of treatment or CONFINEMENT must be given to BCBSUW within 30 days after the commencement of treatment or CONFINEMENT. Failure to give that notice will not invalidate or reduce any claim if it is shown that notice was given as soon as reasonably possible. However, no BENEFITS will be paid for CHARGES incurred in any CALENDAR YEAR unless a claim for those CHARGES is received by BCBSUW within 24 months from the date the service was rendered.
9. Each PARTICIPANT agrees to reimburse BCBSUW or the BOARD for all payments made for BENEFITS to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by BCBSUW or the BOARD. At the option of BCBSUW or the BOARD, BENEFITS for future CHARGES may be reduced by BCBSUW as a set-off toward reimbursement. Acceptance of premiums or paying BENEFITS for CHARGES will not constitute a waiver of the rights of BCBSUW or the BOARD to enforce these provisions in the future.

General Conditions (cont.)

10. BCBSUW will, at its option, pay BENEFITS either to the provider of services or to the SUBSCRIBER.
11. Each PARTICIPANT agrees that the BOARD is subrogated to the PARTICIPANT'S rights to damages for an ILLNESS or INJURY caused by any act or omission of any third person to the extent of BENEFITS.
12. A PARTICIPANT shall not commence any action to recover any BENEFITS or enforce any rights under the CONTRACT until 60 calendar days have elapsed since written notice of claim was given by the PARTICIPANT to BCBSUW, nor will any action be brought more than three years after the services have been provided.
13. Any provisions of the CONTRACT which may be prohibited by law are void, but will not impair any other provision.
14. BCBSUW may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment program if it appears that:
    a. the recommended treatment offers at least equal medical therapeutic value; and
    b. the current treatment program may be changed without jeopardizing the PARTICIPANT'S health; and
    c. the CHARGES incurred for services provided under the recommended treatment will probably be less.

    If the PARTICIPANT or his/her authorized representative and the attending PHYSICIAN agree,

the recommended treatment will be provided as soon as it's available.

BENEFITS payable for the CHARGES incurred for such services shall be paid according to the terms and conditions of the CONTRACT. If the recommended treatment includes services for which BENEFITS are not otherwise payable, payment of BENEFITS will be as determined by BCBSUW.

15. BCBSUW may recommend that an INPATIENT be transferred to another institution if it appears that:
    a. the other institution is able to provide the necessary medical care; and
    b. the physical transfer would not jeopardize the PARTICIPANT'S health or adversely affect the current course of treatment; and
    c. the CHARGES incurred at the succeeding institution will probably be less than those CHARGES at the prior institution.

    If the PARTICIPANT or his/her authorized representative and the attending PHYSICIAN agree to the transfer, the transfer will take place as soon as bed space is available.

B. Preauthorization

BENEFITS are not payable for treatment, services and supplies that are EXPERIMENTAL, INVESTIGATIVE or not MEDICALLY NECESSARY, as determined by BCBSUW. The types of procedures or services that may fall into this category, but not limited to these, are:

1. New medical or biomedical technology;
2. Methods of treatment by diet or exercise;
3. New surgical methods or techniques;

General Conditions (cont.)

4. Acupuncture or similar methods;
5. Transplants of body organs, unless specifically covered under the CONTRACT.

A PARTICIPANT may ask BCBSUW whether or not a treatment, service or supply will be covered and how much in BENEFITS will be paid. If a treatment, service or supply is preauthorized by BCBSUW, no payment can be made unless the PARTICIPANT'S coverage is in effect at the time the treatment, service or supply is provided to the PARTICIPANT.

If a PARTICIPANT does not use this preauthorization procedure, BCBSUW may decide that the treatment, service or supply is EXPERIMENTAL, INVESTIGATIVE or not MEDICALLY NECESSARY. No payment can then be made for the treatment, service or supply or any related treatment, service or supply.

If a PARTICIPANT or his/her PHYSICIAN disagrees with BCBSUW's decision, the PARTICIPANT may appeal that decision by submitting documentation to BCBSUW from the treating PHYSICIAN to the medical value or effectiveness of the treatment, service or supply. The appeal will be reviewed by practicing PHYSICIANS and, if necessary, an appropriate committee of BCBSUW. The decision made at that time will be final.

C. How to File a Claim

1. Present your BCBSUW identification card to the PHYSICIAN, HOSPITAL or other provider of care when a covered service is received. The provider may submit the claim directly to BCBSUW or Medicare. If the provider declines to submit the claim, you should obtain an itemized billing statement and forward it

together with your identification numbers to BCBSUW for processing.

2. For Major Medical Benefits not submitted to BCBSUW by the provider, you must use a Major Medical claim form. You may obtain this form from BCBSUW. Save your itemized bills or statements for all covered Major Medical services. All receipts or bills must be fully itemized. Cash register receipts, cancelled checks and balance due statements are not acceptable. Receipts and bills must be originals. **We do not accept photocopies.**
3. Medicare eligible PARTICIPANTS should include a copy of Medicare's Explanation of Benefits along with the appropriate claim form and receipts. Claims may also be forwarded directly from Medicare to BCBSUW. To implement this service, contact BCBSUW for a Medicare crossover form.
4. Be sure that all receipts and bills include: patient's name; date of service; diagnosis; CHARGE for each date of service; name of the drug or national drug code number and is an official document from the provider or pharmacy. Be sure to use a separate claim form for each family member for each CALENDAR YEAR. After subtracting the deductible and coinsurance, BCBSUW will process the balance of the CHARGES with payment made directly to you.
5. For services outside of Wisconsin, the HOSPITAL or PHYSICIAN can verify your BCBSUW coverage in out of state emergencies by calling toll free during regular working hours.

General Conditions (cont.)

6. Payment is made for reasonable CHARGES incurred anywhere in the United States or Canada. BCBSUW will determine reasonable CHARGES for appropriate medical services or other items required while you are traveling in other countries. Whenever possible, obtain information on foreign currency exchange rates at the time CHARGES were incurred and an English language itemized billing to facilitate processing of your claim when you return home.
7. Even though the provider of services is located outside of Wisconsin, he/she may bill BCBSUW directly. If he/she bills you instead of BCBSUW, simply forward your itemized bill with your SUBSCRIBER identification number to the BCBSUW office at:

   Blue Cross & Blue Shield United of Wisconsin

   P. O. Box 167

   Stevens Point, WI 54481-0167

D. Reasonable Charges

The Group Insurance Board has designed a health insurance CONTRACT which provides full payment of reasonable CHARGES for covered services. The CONTRACT requires that BCBSUW make a determination of and pay such CHARGES. (See the definition of "CHARGE" in the "Definitions" section.)

EMPLOYEES should note the following CONTRACT language:

> “...disputes as to CHARGES will be referred, on a timely basis, to BCBSUW who will attempt to settle the dispute. If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, BCBSUW will undertake the defense of such a suit for the PARTICIPANT or take such other measures as BCBSUW deems necessary to resolve the dispute.”

While in the great majority of cases PHYSICIANS accept the BCBSUW payment as reasonable, an EMPLOYEE may on occasion be asked by the PHYSICIAN to agree verbally or to sign an agreement accepting the responsibility for any CHARGES in excess of those paid by BCBSUW. EMPLOYEES should understand that such a verbal or written agreement about fees with the provider will forfeit full protection under the CONTRACT.

CHARGES in excess of what BCBSUW has determined to be “reasonable” will appear on your Explanation of Benefits (EOB) statement.

If your PHYSICIAN or HOSPITAL bills you for any remaining balance in excess of the reasonable amount, you should:

1. Send all bills you may receive for balances above the reasonable payments made by BCBSUW to the BCBSUW office immediately. Continue sending BCBSUW all such bills you receive. This is the means by which BCBSUW is notified that you are continuing to be billed for the remaining balance.
2. Call BCBSUW immediately if you receive notice that such a balance has been referred for legal action or to a credit or collection agency.

You are not responsible for paying CHARGES in excess of what BCBSUW has determined as reasonable unless you have made an agreement with the service provider to accept this liability.

E. Subrogation

If you elect to be covered under this plan you agree that the Wisconsin Group Insurance Board shall be subrogated to you or your DEPENDENT’S rights to special damages for ILLNESS or INJURY caused by any

act or omission of any third person to the extent that BENEFITS under the plan have been provided and further agree that such rights shall be and are assigned to the Wisconsin Group Insurance Board to such extent. Subrogation simply means that any medical payments provided by this plan become payment due to the BOARD if special damages are awarded.

F. Claim Determination and Appeal Procedures

BCBSUW will send the SUBSCRIBER written notice regarding the claim within 30 days of receiving the claim, unless special circumstances require more time. This notice explains the reason(s) for payment or nonpayment of a claim. If a claim is denied because of incomplete information, the notice indicates what additional information is needed. The SUBSCRIBER may contact the BCBSUW Customer Service department for more details of the decision.

If any SUBSCRIBER has a problem or complaint relating to a benefit determination, he/she should contact BCBSUW. This extends to any "carve-out" services (e.g., prescription drug administrators). BCBSUW will assist the SUBSCRIBER in trying to resolve the matter on an informal basis, and may initiate a Claim Review of the benefit determination. If the SUBSCRIBER wishes, he/she may omit this step and immediately file a Formal Appeal.

General Conditions (cont.)

Claim Review:

A claim review may be done only when a SUBSCRIBER requests a review of denied benefits. When a claim review has been completed, and the decision is to uphold the denial of benefits, the SUBSCRIBER will receive written notification as to the specific reason(s) for the continued denial of benefits and of his/her right to file an appeal.

Urgent Health Concerns:

Appeals related to an urgent health concern (i.e., life threatening), will be handled within four (4) business days of BCBSUW's receipt of the Appeal.

Formal Appeal:

The Appeal request must be received by BCBSUW within 60 days after the SUBSCRIBER was sent written notice regarding the claim. The request may be in any form, but:

1. Must be in writing;
2. Should be identified as a grievance or Claim Appeal;
3. Should specify the date of service, the patient name, amount, and any other identifying information such as the claim number or health care provider, as shown on the denial; and
4. Should provide any other pertinent information such as the identification number, patient's name, date and place of service, and reason for requesting review.

Investigation and resolution of any Appeal will be initiated within five (5) days of the date the Appeal is filed by the SUBSCRIBER in an effort to effect early resolution of the problem.

General Conditions (cont.)

BCBSUW will review the Appeal. BCBSUW will provide a written decision, including reasons, within 60 days of receiving the Appeal. If special circumstances require a longer review period, BCBSUW will provide a written decision within 120 days of receiving the Appeal.

BCBSUW's final decision may be reviewed by the Department of Employee Trust Funds provided the written request for the review is received by the Department within 60 days after the BCBSUW's final decision is sent to the SUBSCRIBER. Decisions not timely appealed to the Department are final.

Please send all claim appeals to:

Blue Cross & Blue Shield United of Wisconsin
Attn.: Claim Appeal Department
P. O. Box 110
Fond du Lac, WI 54936

BCBSUW TELEPHONE NUMBERS AND ADDRESSES

Though we have tried to make this booklet as detailed as possible, you may still have questions about your coverage or membership. When you do, call, write or visit your Regional Service Center listed below.

Call toll free:

1-800-755-6400

TDD 1-800-656-6777

or

Write or Visit:

Blue Cross & Blue Shield United of Wisconsin
Southeastern Wisconsin Regional Service Center
1515 North RiverCenter Drive
Milwaukee, Wisconsin 53212
(414) 226-2233

Southwestern Wisconsin Regional Service Center
19 West Main Street
Evansville, Wisconsin 53536
(608) 882-5967

Western Wisconsin Regional Service Center
2270 Highland Center
Eau Claire, Wisconsin 54701
(715) 836-7737

BCBSUW Telephone Numbers And Addresses (cont.)

Northeastern Wisconsin Regional Service Center
145 South Pioneer Road
Fond du Lac, Wisconsin 54936
(920) 923-4141

The Department of Employee Trust Funds and Blue Cross and Blue Shield United of Wisconsin do not discriminate on the basis of disability in the provision of programs, services, or employment. If you are disabled and need this printed information in a different form or if you need assistance in using our services, please contact one of our Benefit Information or Customer Service offices.

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